Bureau of Health Care Quality and Compliance

	T OF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM				PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				A. BUILDING B. WING	<u> </u>		
		NVS3447HWH				02/2	3/2011
NAME OF PR	OVIDER OR SUPPLIER			RESS, CITY, STA			
VISION HOUSE 1				CER STREET S, NV 89109			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE	
WW000	INITIAL COMMENTS		WW000				
WW013 SS=F	The findings and comby the Health Division prohibiting any crimin claims for relief that munder applicable feder. This Statement of Dear esult of a State Licyour facility on 2/23/1. The survey was cond Administrative Code of for Recovering Alcohologulations, adopted of Health on December date of 01/01/02. The facility is licensed at the time of the survey ADMINISTRATOR GOMEN ADMIN	ducted using Nevada (NAC) 449, Halfway Ho ol and Drug Abusers by the Nevada State E er 17, 2001 with an effect d for 15 beds. The cent vey was five. ENERAL DUTIES I: cility is maintained in a of met as evidenced by: n on 2/23/11, the director acility was maintained in	ation I as er party ed as ed at uses Soard ective sus	WW013			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O		, ,	PLE CONSTRUCTION	(X3) DATE SUF COMPLET	
				A. BUILDING B. WING		C	
		NVS3447HWH				02/2	3/2011
NAME OF PR	OVIDER OR SUPPLIER			RESS, CITY, STA			
VISION HO	OUSE 1			CER STREET S, NV 89109	•		
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WW013	Continued From page 1			WW013			
WW014 SS=C	was covered in mold; room contained dirty bedroom #1 was torn piled to the ceiling in exposed wires in ceili Severity: 2 Scope:		ning le llows rea;	WW014			
	and procedures estab	ove changes in the polic plished pursuant to annually. This review r					
	Based on observation the director failed to pevidence that the faci	ility's policies and ewed on an annual bas	/11,				
WW027	POLICIES AND PRO ESTABLISHMENT; M			WW027			
	policies, procedures a includes the policies a pursuant to subsection	shall maintain a manua and rules of the facility t and procedures establis on 1. The manual must nises of the facility at all	that shed be				

-	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NOME	LIV.	A. BUILDING		C	
		NVS3447HWH		B. WING			3/2011
NAME OF PR	OVIDER OR SUPPLIER			RESS, CITY, STA			
				CER STREET S, NV 89109	•		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODER (DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
WW027	Based on observation the director failed to r	ot met as evidenced by: n and interview on 2/23 maintain a manual of po ne premises of the facili	/11, blicies	WW027			
WW031 SS=E	· · = · · = · · · · · · = · • · · · · ·			WW031			
33-E	facility must be kept r be covered in such a unable to get inside the each week, the conta	to store garbage outside to store garbage outside teasonably clean and manner that rodents and the container. At least container must be emptied a container must be remove the facility.	nust re once ind				
	Based on observation	ot met as evidenced by: n on 2/23/11, the director of containers used to stort e covered.	or				
	Severity: 2 Scope:	2					
WW035 SS=F	HEALTH AND SANIT	TATION		WW035			
	NAC 449.154919:						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C	
		NVS3447HWH		B. WING			3/2011
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	ATE, ZIP CODE		
VISION H	OUSE 1		3614 SPENC LAS VEGAS	CER STREET , NV 89109	•		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
WW035	facility must be kept find (d) Accumulations refuse. This Regulation is not	ticable, the premises or ree from: s of dirt, garbage and of t met as evidenced by:	ther	WW035			
	This Regulation is not met as evidenced by: Based on observation on 2/23/11, the director failed to ensure the facility was free from the accumulation of garbage and refuse (numerous unused bed frames in side yard, broken bicycles throughout side yard and backyard, patio chairs with exposed foam in backyard, cable box with exposed wires in backyard, broken bench press with exposed foam, two car tires on the ground in side yard).		ous cles airs ith ess				
WW037 SS=D	Severity: 2 Scope: HEALTH AND SANIT			WW037			
	. ,	-					
	Based on observation failed to ensure all win opened were not screen		tor J try of				

		(X1) PROVIDER/SUPPLIER/O			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		NVS3447HWH				02/2	3/2011
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
VISION HO	VISION HOUSE 1			CER STREET S, NV 89109			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
WW062 SS=F	2 MEDICATION			WW062			
	at the facility. That m	f-administration may be nedication must: controlled in a manner on from unauthorized u	that				
	This Regulation is not met as evidenced by: Based on observation and interview on 2/23/11, the director failed to ensure the facility had an area or device to store and control medication from unauthorized use.		/11, n				
	Severity: 2 Scope:	3					
WW076 SS=C	CLIENT FILES; MAIN CONFIDEN	NTENANCE; CONTENT	ſS;	WW076			
	maintains a separate	shall ensure that the fac file for each client of th e file for at least 5 years y leaves the facility.	e				
	The file must be kept locked in a location that is protected against unauthorized use. Each file must contain the information obtained by the facility that is related to the client, including, without limitation:		le				
	(a) The full name social security number	, address, date of birth a er of the client.	and				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				A. BUILDING		С	
		NVS3447HWH				02/23/2011	
NAME OF PR	OVIDER OR SUPPLIER			RESS, CITY, STA			
VISION HO	DUSE 1			CER STREET S, NV 89109			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLI	ETE
WW076	Continued From page	e 5		WW076			
	Based upon observate 2/23/11, the director f	failed to ensure client fil location that was prote e.	les				
WW079 SS=F	CLIENT FILES; MAIN CONFIDEN	CLIENT FILES; MAINTENANCE; CONTENTS;		WW079			
	maintains a separate facility and retains the the client permanent! The file must be kept protected against unamust contain the information of the contain the information of the contain the information.	shall ensure that the factile for each client of the effect of at least 5 years y leaves the facility. I locked in a location that authorized use. Each firmation obtained by the to the client, including,	e s after at is				
	(d) Evidence of co provisions of NAC 44	ompliance with the 1A.380.					
		ot met as evidenced by: ew and interview on 2/2					

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBE			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		NVS3447HWH		A. BUILDING B. WING		02/2		
NAME OF DR	OVIDER OR SUPPLIER	NV33447HWH	STREET ADDI	 RESS, CITY, STA	ATE ZIP CODE	02/23	3/2011	
NAME OF PR	OVIDER OR SUPPLIER			CER STREET				
VISION HO	OUSE 1			GAS, NV 89109				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU .SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
WW079	Continued From page 6			WW079				
		49.380 regarding ing (Resident #1, resident #1, resident #5 d two step TB test).						
WW084 SS=E	SAFETY FROM FIRE	:		WW084				
	has a plan for the eva	shall ensure that the fa acuation of clients in car cy. The plan must be:						
	Based on observation the director failed to e were marked as exits	ot met as evidenced by: n and interview on 2/23/ ensure 2 of 5 primary ex (doors leading outside room #5 were not mark	/11, kits from					
	Severity: 2 Scope:	2						
WW091 SS=D	SAFETY FROM FIRE	Ē		WW091				
	maintained in proper times and must be tet the tests conducted p	nstalled in a facility mus operating condition at a tsed monthly. The resul oursuant to this subsect d maintained at the faci	all Its of ion					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
				A. BUILDING			С		
		NVS3447HWH		B. WING		02/	23/2011		
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	•			
VISION H	OUSE 1			SPENCER STREET FEGAS, NV 89109					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE		
WW091	1 Continued From page 7		WW091						
	Based on observation the facility failed to e	not met as evidenced by on and interview on 2/23 ensure smoke detector n 1 out of 12 months (m	/11,						
WWA90 SS=F	WA90 NAC 441A.375 Employee - TB SS=F			WWA90					
	dependent and hom care: Management of cases; surveillance as counseling and prev 1. A case having tube considered to have the facility or a facility for managed in accordade Centers for Disease adopted by reference subsection 1 of NAC 2. A medical facility, a home for individual maintain surveillance or home for tubercul infection. The surveinfection. The surveinfection and Prevent transmission of tube health care set forth Centers for Disease	perculosis or suspected of tuberculosis in a medical or the dependent must be since with the guidelines. Control and Prevention in paragraph (h) of 2 441A.200. a facility for the dependent of employees of the factorial care shall be of employees of the factorial control and tuberculosis. Illance of employees must ance with the factorial for preventing the control in facilities proving the guidelines of the Control and Prevention.	tial s; case l e of the as ent or cility st be e						
	subsection 1 of NAC	e in paragraph (h) of 3 441A.200. loyment, a person emplo	oved						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE SUR\ COMPLETE	
		NVS3447HWH		B. WING		02/23	/2044
NAME OF DE	OVIDER OR SUPPLIER	NV33447HWH	STREET ADD	I RESS, CITY, STA	ATE ZIP CODE	02/23/	/2011
VISION HOUSE 1		3614 SPEN	CER STREET S, NV 89109				
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WWA90	Continued From page 8			WWA90			
	in a medical facility, a a home for individual a: (a) Physical examinat licensed physician that good health, is free frany other communicated stage; and (b) Tuberculosis screepreceding 12 months history of bacillus Calvaccination. If the employee has coff a 2-step Mantoux traceding 12 months 2-step Mantoux traceding 12 months 2-step Mantoux traceding 12 months 2-step Mantoux tuber single-step tuberculos administered. A single screening test must brace unless the medical didesignee or another I determines that the riappropriate for a less documents that deterexposure and correspexamination must be guidelines of the Cen Prevention as adopte (h) of subsection 1 of 4. An employee with a positive tuberculosis sfrom screening with sradiographs unless he suggestive of tubercutosis screening to subsection 3 shall and medical evaluation 6. Counseling and present the supplementation of the counseling and present the supplementation of tubercutosis screening to subsection 3 shall and medical evaluation 6. Counseling and present the supplementation of the counseling and present the counseling a	facility for the dependence residential care shall have re	ave a te of and gious a step of the be ter, ais and githe I and graph f a ot suant graph s. tibe				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O		, ,	PLE CONSTRUCTION	(X3) DATE SURVE COMPLETED	Υ
				A. BUILDING B. WING		С	
		NVS3447HWH				02/23/2	011
NAME OF PF	ROVIDER OR SUPPLIER			RESS, CITY, STA			
VISION H	OUSE 1			CER STREET S, NV 89109			
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WWA90	Continued From page 9			WWA90			
	of the Centers for Dis Prevention as adopte (g) of subsection 1 of 7. A medical facility sl employees for the de- symptoms. A person or a positive tuberculor report promptly to the if any, or to the direct of the medical facility designated an infection any pulmonary sympt of tuberculosis are pro- be evaluated for tuber	d by reference in parage NAC 441A.200. hall maintain surveilland velopment of pulmonar with a history of tuberco sis screening test shall infection control special or or other person in chair the medical facility has no control specialist, whoms develop. If symptoms develop. If symptoms develops in the employee shroulosis.	graph ce of y ulosis l alist, arge as not nen oms				
	Based on interview and the director failed to ecomplied with NAC 44 (Employee #1 -missing		23/11, byees bsis s				